CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH
GILES S. PORTER, M.D., Director

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*Methods in Public Health Administration**

By J. D. DUNSHEE, M.D., City Health Officer, Pasadena

No health department now has, nor can it hope to have, sufficient funds to finance all health work. In times of epidemic or obviously threatened epidemic public support is stimulated by fear but that support is apt to be of methods and procedures of lesser importance in disease control, such as quarantine.

The discoveries of Pasteur, Koch, and others of the association of germs with the cause of disease gave great stimulus to the application of isolation, quarantine, and disinfection. These methods are spectacular and under the stress of public opinion are at times painfully enforced without being much more than a smoke screen behind which the health worker attempts to do intelligent service in real disease control. Mild cases, atypical cases, and carriers keep the battle royal going. An appreciation of this has made health officers realize that control of communicable disease is only possible by the voluntary cooperation of the individual citizen secured through education in personal and family hygiene. Health officers have given up the idea that all health work could be done by persons on the pay roll of the health department. It has become obvious that disease prevention in a wide community problem involving the voluntary participation of many agencies, official and unofficial.

I believe that the main objective of the intelligent health worker is to get the work done and that the matter of who shall do it is of lesser importance.

Unofficial voluntary health agencies in the past have made a great contribution toward the prevention and control of disease by demonstrating that educational methods were effective and legitimate weapons for the use of official health departments. They are still demonstrating the value of new procedures and without their assistance and initiative health departments would have difficulty in bringing about many needed changes. I believe this is a good thing to keep in mind for we should be greatful for this contribution and should realize that such assistance will continue to be needed and may be given.

The part that the organized medical profession should play is scarcely second to that of the health department. The early pioneers in public health administration were physicians and no health department can successfully function without their sympathetic understanding and support. Today, as yesterday, practitioners must practice preventive medicine and they and the health officer must have an appreciation and understanding of each other's problems with a sincere desire to work happily together in the interest of the public and themselves. If, as I believe, for methods of control to operate successfully it is necessary to have close and friendly cooperation between the factors mentioned, it is also necessary to have a common understanding of those methods used and the reasons for their use.

Those of us who have seen active military service in the field will recall that the first duty of a medical officer upon entering a new territory was to familiarize himself with the location of the different dressing stations, their facilities for caring for men; the different possible routes for the evacuation of sick or wounded, and means of transportation, so that if one failed, or was not feasible, another was available and understood. They studied the usual and unusual hazards to the health of the men which must be met. Life was made up of certain routine, proven useful from experience, and of methods, ingenious and otherwise, of attempting to anticipate emergencies and meet them intelligently. It was an excellent training for the work of a health officer whose duties are similar.

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* Read before Health Officers' Section, League of California Municipalities, Monterey, Sept. 23, 1931.

Many health officers are part-time men doing all their own work without assistants, and their department is in theory and in fact a "one-man department." Metaphorically speaking they may be doing major surgery artistically and successfully with a jackknife for a tool. If so, it is because they have a knowledge of their community and its contacts and a grasp of the fundamental principles of public health administration. They have made a survey, perhaps unconsciously, of their field. This includes a knowledge and understanding of the history, position, topography, geology, climate, number, and constitution of their population. They know the source, method of collection and distribution of their water and milk supply, the method of disposal of garbage and sewage. They are aware of the relation of these things to the possible state of the public health. They are aware that no community lives unto itself alone.

Modern transportation facilities have removed the classification of urban, suburban, and rural communities. A man robs a bank in Pasadena and his proven alibi that he was in San Francisco on the forenoon of the day the robbery was committed does not prevent his possible arrest nor remove suspicion entirely from him.

Typhoid fever or smallpox in Imperial County is of concern in Los Angeles and San Francisco and perhaps New York City. A well which has given pure water since man's memory runneth or a dairy conducted by the town's most respected citizen and heaviest taxpayer may become the vehicle for the spread of a devastating epidemic of typhoid fever, if they are not properly protected. Tomorrow either may have somewhere on their line of defense, perhaps as a guest, a lady whose sweet temper is only occasionally marred by the antics of a chronically infected gall bladder harboring germs of a typhoid fever from which she had clinically recovered ten years previous and about which she had almost forgotten. Such things are not fantasies. We recently had such a case in a Pasadena hospital where a nurse caring for a case upon which such a gall bladder had been removed contracted typhoid. The patient had a history of typhoid ten years before followed by a chronic choleoystitis which in our investigation was found to have been harboring typhoid germs and to have caused her to be a carrier. Only the application of modern scientific technique which was habitual in that institution protected it against the possibility of an epidemic of typhoid there. Incidentally, the lack of such application in the personal hygiene of the attendant nurse made of her a victim to typhoid and enabled us to locate this particular carrier.

Probably the vast majority of our carriers will never be apprehended or when so, in many cases too late to protect the community from an epidemic. In such cases the epidemic will disclose their presence. Certainly it seems to me that one of the important values that can accrue from the discovery of the case will be to impress us and the community, which is much more important, with the necessity of removing those factors which might make it easily possible for any case of communicable disease to become epidemic.

People must have a knowledge of the way disease is spread. They must have confidence that their health officer is familiar with the symptoms of the various communicable diseases and the known modes of transfer of those diseases. With some understanding of the reasons why certain measures are adopted by health workers and an established confidence in the worker a high degree of cooperation may be possible.

It is not to be forgotten, when all is said and done, that in many cases upon the degree of immunity of those exposed will probably depend the result rather than upon any method adopted. With some diseases, of course, immunity may not be possible to obtain. With others, namely smallpox and diphtheria, an active immunity may be given. In these it is our duty to secure such immunity. Undoubtedly in many other diseases we gain protection from mild attacks of which we were not aware of having had. We feel poliomyelitis to be an example of such an instance. It seems difficult to explain by any other means the limitation of the spread of this disease in epidemics where its distribution is general but where the actual number proved to be infected is relatively small. Missed mild cases and immunity seems to be a logical answer.

Without these various measures, methods of case discovery may of necessity gain in importance but be applied with doubtful utility. Public health measures in the past must have demonstrated to us by now how helpless we are in the face of present or threatened epidemic if we have not already instituted known measures of protection against avenues for the spread of disease. Malaria, Yellow Fever, Typhoid, and Plague, are historic examples. It is not enough to pasteurize a milk supply after discovery of typhoid on a milk route. We must have anticipated the possibility of milk being a mode of transmission of disease before the appearance of the disease. The same logic applies to water supplies and others.

1931 INTERCHAMBER HEALTH CONTEST PROGRESSES

The American Public Health Association has announced that the 1931 Interchamber Health Conservation Contest, which closes its enrollment records December 31, has an enrollment of 256 cities. Most of these have fewer than 20,000 population. The enrollment, according to population groups, is as follows:

Group I (cities over 500,000 population)—11
Group II (cities from 250,000 – 500,000)—17
Group III (cities from 100,000 – 250,000)—31
Group IV (cities from 50,000 – 100,000)—37
Group V (cities from 20,000 – 50,000)—64
Group VI (cities under 20,000 population)—96

A number of California cities are entered in this contest and several of them have won awards in similar contests that have been held in preceding years. Alhambra, last year, won first honors among cities in its group. San Francisco, Palo Alto, and other California municipalities, have achieved meritorious awards during previous years. It is believed that many California cities will be honored in the 1931 contest.

Although the deadline for submitting material for grading is set for March 1, 1932, the Committee asks that schedules be sent to Washington as soon as possible after January 1. This will facilitate greatly the work of grading and will enable an early announcement of awards to be made.

CHANGE IN PREREQUISITE FOR PUBLIC HEALTH NURSING EXAMINATION

The California State Board of Public Health, at its meeting of December 12, 1931, amended Rule 4 of the regulations governing the examination for public health nursing certificate, which now reads as follows:

> In addition to the two years' practical experience, evidence shall be required showing that the candidate has attended a summer course in *public health nursing* of at least six weeks at the University of California, at Berkeley or Los Angeles, or a course of equal standard at any other university.

This change in the regulations specifies that a summer course taken at one of the universities must be in public health nursing rather than in unrelated or general subjects.

SPOTTED FEVER VACCINE AVAILABLE

Surgeon R. R. Parker, special expert in charge of the United States Public Health Service Rocky Mountain Spotted Fever Laboratory of Hamilton, Montana, has announced that the first supply of Rocky Mountain spotted fever vaccine for the season of 1932 will be available for distribution about February 1. This vaccine is sent out from the laboratory at Hamilton and is forwarded directly to physicians who may apply for it. There are a few requisites that physicians who desire the vaccine should comply with. They may be enumerated as follows:

1. Requests for vaccine should be addressed to the Officer in Charge, United States Public Health Service, Hamilton, Montana.

2. Each request for vaccine should specify either the number of persons to be vaccinated or the number of cubic centimeters needed on the basis of 4 c.c. to the person.

3. Vaccine is furnished to physicians without charge and the fee for administration should be nominal.

4. The vaccine is expensive to manufacture and amounts requested should be limited to use which can be foreseen.

5. Reports received at the Hamilton station suggest that if vaccine is administered soon after a bite by an infected tick a considerable amelioration of symptoms and shortening of the course of infection may result. Physicians will therefore be justified in recommending the taking of the vaccine by tick-bitten persons as soon as possible after the bite is received.

6. Therapeutic use of the vaccine after onset of symptoms is not recommended. In sections where the less fatal types of infection occur, some physicians have so used it with supposed good results, but the difficulties which prevent certainty on this point can be readily understood. Results in the highly fatal Bitter Root Valley cases have suggested that in the more severe type of the disease, its use may even be harmful.

7. It is especially requested that the Officer in Charge of the Hamilton laboratory be advised of any cases of spotted fever which may occur in vaccinated persons and that as detailed a clinical record as possible be kept of such cases.

The doctor is the first person we meet when we come into the world, and unless we go out by accident, he is the last with us when we leave it. Such devotion is worthy of the highest praise, and that is often all the doctor gets for it.—*Lampton.*

MORBIDITY*

Diphtheria.

105 cases of diphtheria have been reported, as follows: Oakland 1, Fresno County 1, Fresno 2, Kern County 2, Bakersfield 1, Los Angeles County 14, Burbank 1, Compton 2, Glendale 1, Huntington Park 1, Inglewood 1, Long Beach 2, Los Angeles 36, Pomona 1, San Fernando 1, Santa Monica 2, Torrance 2, Maywood 1, Gardena 1, Orange County 1, Anaheim 1, Fullerton 4, Huntington Beach 1, Santa Ana 6, La Habra 1, Sacramento 1, San Bernardino 1, San Diego 5, San Francisco 4, Sonoma County 3, Modesto 2, Tulare County 1, Lindsay 1.

Scarlet Fever.

127 cases of scarlet fever have been reported, as follows: Berkeley 1, Oakland 7, Piedmont 1, Butte County 2, Colusa 2, Contra Costa County 3, Martinez 2, Fresno County 1, Fresno 4, Orland 3, Los Angeles County 7, Alhambra 1, Compton 5, El Segundo 1, Glendale 3, Inglewood 5, Long Beach 3, Los Angeles 31, Pomona 1, San Fernando 1, Santa Monica 1, San Anselmo 1, Orange County 1, Anaheim 4, Fullerton 1, National City 1, San Diego 3, San Francisco 5, San Joaquin County 3, Stockton 1, Santa Barbara County 5, San Jose 1, Santa Cruz 2, Vallejo 2, Sonoma County 2, Stanislaus County 1, Modesto 1, Yuba City 2, Tulare County 3, Lindsay 2, Tulare 1.

Measles.

99 cases of measles have been reported, as follows: Alameda 1, Berkeley 1, Piedmont 2, Arcata 1, Eureka 6, Los Angeles 5, Monterey County 4, Monterey 1, Pacific Grove 3, Napa County 1, Napa 1, Sacramento 36, Hollister 1, San Francisco 16, Stockton 1, Santa Clara County 11, San Jose 1, Santa Cruz 5, Vallejo 1, Davis 1.

Smallpox.

2 cases of smallpox have been reported, as follows: Coalinga 1, San Francisco 1.

Typhoid Fever.

6 cases of typhoid fever have been reported, as follows: Kern County 1, San Francisco 2, Stanislaus County 1, Tulare County 2.

Whooping Cough.

85 cases of whooping cough have been reported, as follows: Berkeley 4, Oakland 5, Contra Costa County 2, Los Angeles County 9, Burbank 1, Inglewood 1, Los Angeles 9, Santa Monica 1, Hawthorne 1, Orange County 1, Orange 1, National City 6, San Diego 5, San Francisco 3, San Joaquin County 12, Stockton 12, Santa Barbara County 2, Santa Maria 6, San Jose 4.

Meningitis (Epidemic).

4 cases of epidemic meningitis have been reported, as follows: Oakland 1, Fresno County 1, San Diego 1, San Francisco 1.

Poliomyelitis.

2 cases of poliomyelitis have been reported, as follows: Los Angeles 1, Los Gatos 1.

Undulant Fever.

2 cases of undulant fever have been reported, as follows: Kern County 1, Modesto 1.

Typhus Fever.

One case of typhus fever from South Gate was reported.

Coccidioidal Granuloma.

One case of coccidioidal granuloma from Santa Ana was reported.

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* From reports received on December 21st and 22d, for week ending December 19th.

COMMUNICABLE DISEASE REPORTS

Disease	1931				1930			
	Week ending			Reports for week ending Dec. 19 received by Dec. 22	Week ending			Reports for week ending Dec. 20 received by Dec. 23
	Nov. 28	Dec. 5	Dec. 12		Nov. 29	Dec. 6	Dec. 13	
Actinomycosis	0	0	0	0	1	0	0	0
Anthrax	1	0	0	0	0	0	0	0
Chickenpox	245	324	381	324	240	389	508	167
Coccidioidal Granuloma	0	0	0	1	0	0	1	0
Diphtheria	101	123	83	105	84	65	69	61
Dysentery (Amoebic)	4	2	2	1	1	0	5	5
Dysentery (Bacillary)	8	5	0	3	10	2	7	4
Encephalitis (Epidemic)	0	1	1	0	2	0	0	0
Erysipelas	16	16	20	17	13	7	14	8
Food Poisoning	5	1	1	0	10	0	0	0
German Measles	5	7	4	12	9	10	6	6
Gonococcus Infection	144	133	190	138	156	145	198	138
Hookworm	0	0	0	0	0	1	0	0
Influenza	42	70	116	104	50	69	50	73
Jaundice (Epidemic)	0	0	1	0	0	0	0	0
Leprosy	0	0	0	0	1	0	0	1
Malaria	0	0	2	2	0	0	0	0
Measles	119	242	157	99	197	270	233	223
Meningitis (Epidemic)	5	5	8	4	4	7	4	5
Mumps	96	114	145	74	137	220	229	111
Ophthalmia Neonatorum	0	0	0	0	1	0	0	1
Paratyphoid Fever	1	1	3	1	0	0	0	1
Pellagra	1	1	1	2	5	2	1	2
Pneumonia (Lobar)	51	73	91	101	114	85	61	74
Poliomyelitis	3	8	3	2	28	13	14	19
Rabies (Animal)	6	6	7	5	35	18	22	18
Scarlet Fever	134	148	167	127	102	108	111	84
Septic Sore Throat	1	1	2	0	0	0	0	0
Smallpox	14	20	6	2	80	41	52	54
Syphilis	167	141	205	172	216	162	202	165
Tetanus	0	0	2	1	1	0	3	0
Trachoma	2	3	3	0	4	1	7	2
Trichinosis	1	0	0	0	0	0	0	2
Tuberculosis	184	177	173	113	155	250	231	139
Tularemia	0	1	0	0	0	0	0	0
Typhoid Fever	10	12	11	6	11	17	4	10
Typhus Fever	0	0	0	1	0	0	1	0
Undulant Fever	2	1	5	2	3	0	3	0
Whooping Cough	73	117	130	85	108	109	116	86
Totals	1,441	1,753	1,920	1,504	1,778	1,991	2,152	1,459

Diphtheria continues on a higher level.

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Influenza is still higher than normal.

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Measles is less prevalent.

* * *

Whooping cough shows a reduction.

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A case of typhus fever was reported last week.

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